



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ROBERT E. URREA, MD

Respondent Name

EAST TX EDUCATIONAL INS ASSN

MFDR Tracking Number

M4-15-3984-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

AUGUST 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We reported CPT code 99080 for a report prepared by Dr. Urrea in response to a letter from Abby Heredia, Claim Representative. She provided a list of questions that Dr. Urrea responded to. The bill was denied by the carrier stating 'this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received or adjudicated.' Payment was disallowed because the only charge reported was for 99080 for \$100. We disagree with their determination. Dr. Urrea completed the form letter and should receive compensation for his services as per Rule 134.120."

Amount in Dispute: \$100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dr. Urrea indicates reimbursement should be issued based on Rule 134.120, however this rule would not be applicable, as we did not request repeat medical records or the creation of a narrative report. Based on medical records from date of Service 1/15/15, the claimant's MRI, incurred on 12/19/14 indicated left complete tear of the supraspinatus and infraspinatus tendon. Our letter to Dr. Urrea was an attempt to determine if the results of the MRI were pre-existing to the work injury of [Date]. We have attached a copy of our original request prior to Dr. Urrea completing it. We have also attached copies of the medical records from date of service 1/15/15 with Dr. Urrea as well as the MRI report for date of service 12/19/14. It is our position that based on Rule 133.120 reimbursement in the amount of \$100.00, for a special report, would not be due and denial should be maintained."

Response Submitted By: Claims Administrative Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 30, 2015	CPT Code 99080	\$100.00	\$100.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.120, effective May 2, 2006, sets out the reimbursement guideline for medical documentation.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
 - 745-Payment adjusted due to required modifier missing or billed modifier invalid for procedure code.
 - B15-This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
 - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Is the requestor entitled to reimbursement?

Findings

On the disputed date of service, the requestor billed code 99080 for a narrative report. According to the submitted explanation of benefits, the respondent initially denied reimbursement for code 99080 based upon reason codes "4" and "745." A review of the Division's fee guidelines finds that a modifier is not required for narrative reports; therefore, the respondent's denial based upon reason codes "4" and "745" is not supported.

Upon reconsideration, the respondent denied reimbursement for code 99080 based upon reason code "B15." The respondent contends that reimbursement is not due because "we did not request repeat medical records or the creation of a narrative report."

CPT code 99080 is defined as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

28 Texas Administrative Code §134.120(g) defines narrative reports as "original documents explaining the assessment, diagnosis, and plan of treatment for an injured employee written or orally transcribed and created at the written request of the insurance carrier or the Division..."

28 Texas Administrative Code §134.120(b) states, "An insurance carrier shall separately reimburse subsequent copies of medical documentation requested by the insurance carrier in accordance with §133.210 of this title."

28 Texas Administrative Code §134.120 (f)(5)(A) states, "The reimbursements for medical documentation are: (5) narrative reports: (A) one to two pages--\$100."

A review of the submitted documentation finds that the respondent's representative, Abby Heredia, wrote Dr. Urrea a couple of questions regarding the claimant's condition and how it related to the claimant's workers' compensation compensable injury. Dr. Urrea, submitted a copy of a one page report that answered her

questions. The Division finds that the requestor supported that reimbursement is due in accordance with **28** Texas Administrative Code §134.120. As a result, reimbursement of \$100.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$100.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$100.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	09/03/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.